INDEPENDENT REVIEWERS OF TEXAS, INC.

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[Date notice sent to all parties]:

07/11/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: SI joint injection x1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Pain Medicine

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
☐ X Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male. He reported pain and numbness occupational therapy the low back. On X/XX/XX, the patient was seen in clinic. On exam, strength was 5/5, there was a positive straight leg raise and gait and station were normal. On X/XX/XX, the patient returned to clinic with continued complaints of low back pain. On exam, reflexes were 2+ and there was tenderness over the lumbar paraspinal muscles in the SI joint region.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
On X/X/XX, a utilization review report stated the requested SI joint injection, was reviewed screen ODG and it was noted that the injection was not recommended for mechanical SI joint dysfunction, and there was some complaints to suggest right sacroiliac issues, but there was no indication of inflammatory spondyloarthropathy or sacroiliitis. The request was non-certified. On X/XX/XX, a utilization review report also stated the request was non-certified, as there was no indication of spondyloarthropathy.
The guidelines do not support SI joint injections unless there is evidence of spondyloarthropathy, which has not been documented for this patient.
It is the opinion of this reviewer that the request for an SI joint injection x1 is not

medically necessary and the prior denials are upheld.

IRO REVIEWER REPORT TEMPLATE -WC

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☐ **X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☐ **X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**